STATE OF MICHIGAN

DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 122257-001-SF**

v

Blue Cross Blue Shield of Michigan
Respondent

Issued and entered
this _18th___ day of January 2012
by R. Kevin Clinton
Commissioner

ORDER

I. PROCEDURAL BACKGROUND

On July 7, 2011, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under the Public Act No. 495 of 2006, MCL 550.1951 *et seq*. Act 495 authorizes the Commissioner to conduct external reviews for state and local government employees who receive health care benefits in a self-funded plan. Under Act 495, the reviews are conducted in the same manner as reviews conducted under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Petitioner receives health care benefits as an eligible dependent under her husband's group coverage through the XXXX, a self-funded group. Blue Cross Blue Shield of Michigan (BCBSM) administers the benefit plan whose terms are found in BCBSM's *Community Blue Group Benefits Certificate* (the certificate) and two related riders that govern copayment requirements.

The issue in this external review can be decided by a contractual analysis. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II. FACTUAL BACKGROUND

On June 16, 2010, the Petitioner went to the emergency room at XXXXX Hospital in XXXXX. Following her initial treatment she was seen in the hospital's observation room by Dr. XXXXX who is not a BCBSM participating physician. The Petitioner was then transferred to XXXXX Regional Hospital in XXXXX which has an inpatient cardiac care unit.

BCBSM processed the claims for the Petitioner's care at both hospitals. For the treatment provided by nonparticipating providers, BCBSM assessed the copayment required under the Petitioner's *Community Blue* certificate and rider *CBC 50% NP*, leaving Petitioner with a balance of $325.53 owing to the providers. In her appeal, the Petitioner acknowledged that her care in XXXXX, because it was not emergency care, would be subject to the copayment requirements BCBSM required. The Petitioner has challenged BCBSM's determination that Dr. XXXXX care should be subject to a copayment requirement.

The Petitioner appealed BCBSM's application of the nonpanel copayment. BCBSM held a managerial-level conference, and issued a final adverse determination dated May 10, 2011.

III. ISSUE

Is BCBSM required to pay an additional amount for the Petitioner's physician care related to the June 16, 2010 observation care?

IV. ANALYSIS

Petitioner's Argument

In her request for external review the Petitioner wrote:

> I seek reimbursement for co-pay charges I paid for medical services that were rejected by BCBSM in an appeal to BCBSM for reimbursement.
>
> These charges stem from my being taken by ambulance to XXXXX Hospital in XXXXX, MI, where medical services were provided in the emergency room by a XXXXX. Inc. doctor (Dr. XXXXX), who apparently is not a participating member of my BCBSM PPO program. She was called in by the attending emergency room physician to see me in the emergency room.
>
> * * *
>
> According to the BCBS rejection letter…the 'copayment does not apply when…you receive services for the initial exam to treat a medical emergency or an accident injury in the outpatient department of a hospital, urgent care

> center or physician's office.'
>
> So why was the XXXXX charges subject to the co-pay? Seems I should be reimbursed the $144.33 as I was seen by this physician in the emergency room.
>
> Since I was not in the emergency room at XXXXX [XXXXX], I guess I am responsible for that co-pay of $185.20, even though I did not have the option of selecting those physicians who treated me as I would do under normal circumstances.

BCBSM's Argument

In its May 10, 2011 final adverse determination issued to the Petitioner, BCBSM explained it claims decision:

> You are covered under the *Community Blue Group Benefits Certificate* which is amended by *Rider CBC 50% NP and Rider CB-CM-NP $5000.* These riders increase you copayment requirement to 50 percent for most covered nonpanel services up to an annual maximum of $5,000 for one member ($10,000 for a family).
>
> This copayment does not apply when:
>
> - A panel provider refers you to a nonpanel provider
>   NOTE: You must obtain the referral before receiving the referred service or the service will be subject to the nonpanel copayment requirement
> - You receive services for the initial exam to treat a medical emergency or an accidental injury in the outpatient department of a hospital, urgent care center or physician's office
> - You receive services from a provider which has no PPO panel
> - You receive services from a nonpanel provider in a geographic area in Michigan deemed a "low access area" by BCBSM for that particular provider specialty
>
> None of the circumstances indicated above apply to your observation room care at XXXXX Hospital or your inpatient medical care at XXXXX Regional Hospital. These services were provided by XXXXX, MD XXXXX, DO. Both Dr XXXXX and Dr. XXXXX are nonpanel providers. As a result, we are unable to waive the nonpanel copay applied to their services.

Commissioner's Review

The Petitioner received cardiac care at three facilities during the period July 16-19, 2010. She was initially seen at an urgent care center in XXXXX, transferred to a hospital in

XXXXX, then transferred to the cardiac care unit of a hospital in XXXXX. The providers of this care billed $33,400 for their treatment. BCBSM approved payment of $16,800 and assessed the Petitioner copayments of $325.53 for care received at XXXXX and XXXXX. The providers are BCBSM participating providers and accepted the BCBSM approved amount as payment in full. The copayments were assessed for the care provided by two physicians at XXXXX and XXXXX.

The Petitioner agrees that it was appropriate for BCBSM to assess a copayment in connection with the Petoskey physician care. She disputes the $140.33 XXXX copayment because she believes all the care at XXXX was emergency care. However, the explanation of benefit forms submitted to the Commissioner show that the XXXX copayment was not for emergency treatment but was for services provided while the Petitioner was on observation status at XXXXX awaiting transfer to XXXX. These services are not emergency treatment and, for that reason, were appropriately assessed a copayment.

V. ORDER

BCBSM's final adverse determination of May 10, 2011, is upheld. BCBSM is not required to provide any additional payment for the Petitioner's care.

This is a final decision of an administrative agency. Any person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2). A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.

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R. Kevin Clinton
Commissioner